Filling in the Questionnaire

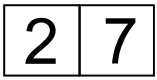
Please use a **black** pen. To answer questions simply put a **cross** (not a tick) in the circle/box which is most accurate in your opinion, like this:

If you make a mistake, shade the circle/box in like this:

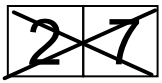
then cross the correct circle/box.

If you are answering questions which ask you to give further details, please make sure you write inside the boxes. If possible, please use CAPITAL LETTERS.

When writing numbers inside boxes, please don't touch the sides of the box.



If you make a mistake when writing numbers inside boxes, please cross through the box and write your answer next to the box.



Please read each question carefully. Some questions are very similar to others or refer to different time periods.

If you do not want to answer a question, or if it does not apply to you, leave it blank.

There is a blank space available at the back of the questionnaire if you need additional space. If you use this sheet, please clearly indicate the question number you are answering.

Contents

Please complete the questionnaire using a BLACK PEN

Section A: General Health

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

This section asks you about your health and any hospital stays or operations you might have had.

A1) Which of the following would you say best describes your health nowadays and during the pandemic (from March 2020 to March 2022)?

		Fit and well	Mostly fit and well	Often unwell	Hardly ever well
a.	Nowadays	1 ○	2 ○	3 ○	4 ○
b.	During the pandemic	1 ○	2 ○	3 ○	4 ○

A2) Have you been admitted to hospital **since the start of the pandemic** (March 2020)?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question A3 on the next page**

If <u>yes</u>:

a. How many times? ☐☐

b. Please list the reasons for each admission:

i) Admission 1:

ii) Admission 2:

iii) Admission 3:

iv) Other admission(s):

19178

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

A3) Have you had any of these operations **since your study child was born** and, if yes, how old were you at the time?
Please answer 'no' or give the age(s) at which you had the operation(s).

		No	Yes, under 25	Yes, 25 – 49	Yes, 50 or older	Yes, age not known
a.	Hernia	0 ○	1 ○	2 ○	3 ○	4 ○
b.	Appendix removed	0 ○	1 ○	2 ○	3 ○	4 ○
c.	Tonsils and/or adenoids out	0 ○	1 ○	2 ○	3 ○	4 ○
d.	Gall bladder removed	0 ○	1 ○	2 ○	3 ○	4 ○
e.	Hysterectomy	0 ○	1 ○	2 ○	3 ○	4 ○
f.	Plastic surgery *Please cross and describe*	0 ○	1 ○	2 ○	3 ○	4 ○

		No	Yes, under 25	Yes, 25 – 49	Yes, 50 or older	Yes, age not known
g.	Caesarean section	0 ○	1 ○	2 ○	3 ○	4 ○
h.	Hip replacement	0 ○	1 ○	2 ○	3 ○	4 ○
i.	Knee replacement	0 ○	1 ○	2 ○	3 ○	4 ○
j.	Cataract removal	0 ○	1 ○	2 ○	3 ○	4 ○
k.	Pacemaker inserted	0 ○	1 ○	2 ○	3 ○	4 ○
l.	Colostomy operation	0 ○	1 ○	2 ○	3 ○	4 ○
m.	Other operation(s) *Please cross and describe*	0 ○	1 ○	2 ○	3 ○	4 ○

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

A4) How would you rate your hearing in each ear, without hearing aids?

		Always very good	Occasional problems (e.g. infections or glue ear)	There are some sounds I cannot hear	Never very good	I cannot hear much at all
a.	Left ear	1 ○	2 ○	3 ○	4 ○	5 ○
b.	Right ear	1 ○	2 ○	3 ○	4 ○	5 ○

c. Do you have a hearing aid?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question A5 below**

If <u>yes</u>:

d. How often do you use it?

Most of the time 3 ○ Sometimes 2 ○

Hardly ever 1 ○ Never 0 ○

A5) Do you get or have you had noises (such as ringing or buzzing) in your head, or in one or both ears, that lasts for more than five minutes at a time?

Yes, most of the time 3 ○ Yes, a lot of the time 2 ○

Yes, some of the time 1 ○ No, not at all 0 ○

A6) How would you rate your sight without glasses or contact lenses?
Please select all that apply

		Always very good	I can't see clearly at a distance	I can't see clearly close up	I cannot see much at all
a.	Left eye	1 ☐	2 ☐	3 ☐	4 ☐
b.	Right eye	1 ☐	2 ☐	3 ☐	4 ☐

A7) Do you wear glasses or contact lenses?

		Yes, always	Yes, sometimes	No, never
a.	Glasses	2 ○	1 ○	0 ○
b.	Contact lenses	2 ○	1 ○	0 ○

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

A8) How often do you have the following nowadays?

		Almost all the time	Sometimes	Not at all
a.	Back ache	2 ○	1 ○	0 ○
b.	Knee pain	2 ○	1 ○	0 ○
c.	Neck ache	2 ○	1 ○	0 ○
d.	Shoulder ache	2 ○	1 ○	0 ○
e.	Pain in other joints	2 ○	1 ○	0 ○
f.	Chest pain	2 ○	1 ○	0 ○
g.	Headaches	2 ○	1 ○	0 ○
h.	Stomach aches	2 ○	1 ○	0 ○
i.	Earache	2 ○	1 ○	0 ○

A9) Has a doctor ever told you that you have:

		Yes, had in past	Yes, have now	No, never
a.	Angina	2 ○	1 ○	0 ○
b.	Fibromyalgia	2 ○	1 ○	0 ○
c.	Rheumatoid arthritis	2 ○	1 ○	0 ○
d.	Rheumatism	2 ○	1 ○	0 ○
e.	Osteoarthritis	2 ○	1 ○	0 ○
f.	Other type of arthritis *Please cross and describe*	2 ○	1 ○	0 ○

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

A10) What types of pain killers do you use for any aches and pains?
Please cross one answer on each line

		Every day	Often	Sometimes	Never
a.	Paracetamol	3 ○	2 ○	1 ○	0 ○
b.	Ibuprofen	3 ○	2 ○	1 ○	0 ○
c.	Aspirin	3 ○	2 ○	1 ○	0 ○
d.	Codeine	3 ○	2 ○	1 ○	0 ○
e.	Naproxen	3 ○	2 ○	1 ○	0 ○
f.	Co-codamol	3 ○	2 ○	1 ○	0 ○
g.	Something else *Please cross and describe*	3 ○	2 ○	1 ○	0 ○

A11) Are there any problems for which you have regular treatment or medicine nowadays?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to section B on page 9**

If <u>yes</u>:

a. Please describe these problems and regular treatment or medicine:

	a) Problem	b) Treatment or medicine
1		
2		
3		
4		
5		

Please use the space provided on page 41 to continue, if you need more space, stating clearly that you are answering question A11a.

If you are affected by any of the issues raised in this section, you may wish to seek support from:

YOUR LOCAL GP

Children of the 90s always recommend that you speak to your GP (doctor) if you have any concerns about your physical or mental health.

www.nhs.uk/nhs-services/services-near-you/

PAIN SUPPORT

Help and support for people in pain.

painuk.org/help-and-support

HEARING SUPPORT

Support, information and guidance about hearing loss.

hearinglink.org/services/helpdesk

Tel: 01844 348 111

Section B: Allergies and Breathing

This section asks about allergies and any problems you might have with your breathing.

B1) Would you say that you are allergic to anything?

Yes 1 ○ No 0 ○ → **If no, please go to question B2 on the next page**

If yes:

a. Is it to: *Please answer yes or no on each line*

		Yes	No
i)	Cat hair	1 ○	0 ○
ii)	Other animal hair	1 ○	0 ○
iii)	Pollen	1 ○	0 ○
iv)	Dust	1 ○	0 ○
v)	Insect bites or stings	1 ○	0 ○
vi)	Peanuts	1 ○	0 ○
vii)	Other types of nut	1 ○	0 ○
viii)	Other foods *Please cross and describe*	1 ○	0 ○
ix)	Medication (e.g. penicillin) *Please cross and describe*	1 ○	0 ○
x)	Something else *Please cross and describe*	1 ○	0 ○

19178

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

B2) How often have you had the following **in the past year**?

		Often	Sometimes	Not at all
a.	Attacks of wheezing with whistling on the chest	2 ○	1 ○	0 ○
b.	A dry itchy rash	2 ○	1 ○	0 ○
c.	A blotchy blistery rash (hives)	2 ○	1 ○	0 ○
d.	Sneezing attacks	2 ○	1 ○	0 ○
e.	Runny nose	2 ○	1 ○	0 ○
f.	Watery eyes	2 ○	1 ○	0 ○
g.	Attacks of breathlessness	2 ○	1 ○	0 ○
h.	Feelings of anxiety or panic about your breathing	2 ○	1 ○	0 ○
i.	Light-headedness or dizziness with breathlessness	2 ○	1 ○	0 ○
j.	Sighing or yawning	2 ○	1 ○	0 ○
k.	Feelings of breathlessness after only minor exercise	2 ○	1 ○	0 ○
l.	Pins and needles in the hands or arms or around the mouth	2 ○	1 ○	0 ○
m.	Difficulty coordinating breathing and talking	2 ○	1 ○	0 ○
n.	Coughing often during the night	2 ○	1 ○	0 ○
o.	Coughing often when you wake in the morning	2 ○	1 ○	0 ○

B3) Have you ever assumed or been told that you have hay fever?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B4 below**

a. About how old were you when you were first aware of having hay fever? ☐☐ Cross this box if you don't know 1 ☐

b. Do you still get hay fever? Yes 1 ○ No 0 ○

c. Do you take medication for hay fever? Yes 1 ○ No 0 ○

If <u>yes</u>, what sort of medication?

B4) Have you ever been told by a doctor that you had eczema?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B5 below**

a. About how old were you when you were first told? ☐☐ Cross this box if you don't know 1 ☐

b. Do you still get eczema?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B5 below**

c. Do you use medications (e.g. creams, lotions, ointments) for eczema? Yes 1 ○ No 0 ○

If <u>yes</u>, what medications do you use for eczema?

B5) Have you ever been told by a doctor that you had asthma?

Yes 1 ○ No 0 ○ → **If no, please go to question B6 on the next page**

a. How old were you when you were first told? ☐☐ Cross this box if you don't know 1 ☐

b. Have you ever needed oral corticosteroids (e.g. prednisolone tablets for an asthma attack)?

Yes, recently (in the past year) 2 ○

Yes, in the past 1 ○

No 0 ○

c. Do you still have asthma?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B6 below**

d. Are you taking any other medication for asthma nowadays?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to e below**

If <u>yes</u>, what asthma medication are you taking?

e. Would you be interested in taking part in a follow-up interview about how you are coping with asthma?

Yes 1 ○ No 0 ○

B6) These questions are about your breathing. Please give the answer for each statement which best matches your breathing nowadays.

		Not at all	Mild	Mode-rate	Severe
a.	My breath does not go in all the way	0 ○	1 ○	2 ○	3 ○
b.	My breathing requires more work	0 ○	1 ○	2 ○	3 ○
c.	I feel short of breath	0 ○	1 ○	2 ○	3 ○
d.	I have difficulty catching my breath	0 ○	1 ○	2 ○	3 ○
e.	I cannot get enough air	0 ○	1 ○	2 ○	3 ○
f.	My breathing is uncomfortable	0 ○	1 ○	2 ○	3 ○
g.	My breathing is exhausting	0 ○	1 ○	2 ○	3 ○
h.	My breathing makes me feel depressed	0 ○	1 ○	2 ○	3 ○
i.	My breathing makes me feel miserable	0 ○	1 ○	2 ○	3 ○
j.	My breathing is distressing	0 ○	1 ○	2 ○	3 ○
k.	My breathing makes me agitated	0 ○	1 ○	2 ○	3 ○
l.	My breathing is irritating	0 ○	1 ○	2 ○	3 ○

B7) Have you ever been told by a doctor that you had a chronic lung condition?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question B8 on the next page**

a. About how old were you when you were first told? ☐☐ Cross this box if you don't know 1 ☐

b. Did you have any of these diagnoses and are they still present?

		No	Yes, still present	Yes, in past
i)	COPD (Chronic Obstructive Pulmonary Disease)	0 ○	1 ○	2 ○
ii)	Chronic bronchitis	0 ○	1 ○	2 ○
iii)	Emphysema	0 ○	1 ○	2 ○
iv)	Pulmonary fibrosis	0 ○	1 ○	2 ○
v)	Bronchiectasis	0 ○	1 ○	2 ○
vi)	Other	0 ○	1 ○	2 ○

Please cross and describe

c. What treatment were you recommended to have?

i) Medication Yes 1 ○ No 0 ○

If <u>yes</u>, what medication?

ii) Exercises Yes 1 ○ No 0 ○

If <u>yes</u>, are you doing them nowadays? Yes 1 ○ No 0 ○

iii) Other treatment Yes 1 ○ No 0 ○

If <u>yes</u>, what other treatment?

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

B8) Have you ever had any of the following?

		Yes, in the past	Yes, in the last 2 years	Not at all
a.	Frequent chest infections (at least 2 per year)	2 ○	1 ○	0 ○
b.	Admission to hospital due to a lung condition	2 ○	1 ○	0 ○
c.	Time off work due to a lung condition	2 ○	1 ○	0 ○
d.	Other lung condition *Please cross and describe*	2 ○	1 ○	0 ○

If you are affected by any of the issues raised in this section, you may wish to seek support from:

YOUR LOCAL GP

Children of the 90s always recommend that you speak to your GP (doctor) if you have any concerns about your physical or mental health.

www.nhs.uk/nhs-services/services-near-you/

Section C: More About Your Health

This section asks about any other health problems or illnesses that you might have.

C1) How often do you have the following nowadays?

		Almost all the time	Sometimes	Not at all
a.	Indigestion	2 ○	1 ○	0 ○
b.	Nausea	2 ○	1 ○	0 ○
c.	Vomiting	2 ○	1 ○	0 ○
d.	Diarrhoea (the runs)	2 ○	1 ○	0 ○
e.	Piles (haemorrhoids)	2 ○	1 ○	0 ○
f.	Constipation	2 ○	1 ○	0 ○
g.	IBS (irritable bowel syndrome)	2 ○	1 ○	0 ○
h.	Crohn's disease	2 ○	1 ○	0 ○
i.	Ulcerative colitis	2 ○	1 ○	0 ○
j.	Other gut problems *Please cross and describe*	2 ○	1 ○	0 ○

C2) Have you ever been told by a doctor that you had diabetes?

Yes 1 ○ No 0 ○ → **If no, please go to question C3 on the next page**

a. How old were you when you were first told? ☐☐

b. Which type of diabetes?

Type 1 1 ○ Type 2 2 ○ Not sure 9 ○

c. What treatment do/did you use to control it? *Please select all that apply*

None 0 ☐ Insulin 1 ☐

Diet 2 ☐ Other medication 3 ☐

continued on the next page

continued:

d. If you have been pregnant, have you only had it when pregnant? (gestational diabetes)

Yes 1 ○ No 0 ○ Not applicable 9 ○

If <u>yes</u>, please go to question C3 below

e. Would you be interested in taking part in a follow-up interview about how you are coping (or have coped) with diabetes?

Yes 1 ○ No 0 ○

C3) Have you ever been told by a doctor that you had hypertension or high blood pressure?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question C4 below**

a. How old were you when you were first told? ☐☐

b. Have you only had it when pregnant?

Yes 1 ○ No 0 ○ Not applicable 9 ○

c. Do you still have high blood pressure?

Yes 1 ○ No 0 ○

d. What was the latest reading? *Enter like 120/80* ☐☐☐ / ☐☐☐

Cross this box if you don't know 1 ☐

C4) How often do you have the following nowadays?

		Almost all the time	Sometimes	Not at all
a.	Psoriasis	2 ○	1 ○	0 ○
b.	Urinary infection or cystitis	2 ○	1 ○	0 ○
c.	Varicose veins	2 ○	1 ○	0 ○
d.	Headache or migraine	2 ○	1 ○	0 ○
e.	Fatigue or tiredness	2 ○	1 ○	0 ○

C5) Has a doctor ever told you that you have or have had any of the following:

		Yes, had it recently	Yes, in past	No, not at all
a.	Kidney disease	2 ○	1 ○	0 ○
b.	Liver disease	2 ○	1 ○	0 ○
c.	Epilepsy	2 ○	1 ○	0 ○
d.	Multiple sclerosis	2 ○	1 ○	0 ○
e.	ME or chronic fatigue syndrome	2 ○	1 ○	0 ○
f.	Long Covid	2 ○	1 ○	0 ○
g.	Stomach ulcer	2 ○	1 ○	0 ○
h.	Cancer *Please cross and describe type*	2 ○	1 ○	0 ○
i.	Pelvic inflammatory disease	2 ○	1 ○	0 ○
j.	Heart attack	2 ○	1 ○	0 ○
k.	A Stroke	2 ○	1 ○	0 ○
l.	Depression	2 ○	1 ○	0 ○
m.	PTSD (Post-traumatic stress disorder)	2 ○	1 ○	0 ○
n.	Anorexia	2 ○	1 ○	0 ○
o.	Bulimia	2 ○	1 ○	0 ○
p.	Binge eating disorder	2 ○	1 ○	0 ○
q.	Anxiety	2 ○	1 ○	0 ○
r.	Alcoholism	2 ○	1 ○	0 ○
s.	Drug addiction	2 ○	1 ○	0 ○
t.	Other type of addiction *Please cross and describe*	2 ○	1 ○	0 ○

C6) How tall are you?
Please either enter the number of whole feet in one box (e.g. 5) and the inches in the next box (e.g.7), or, alternatively, enter the number of whole centimetres in the third box.

a. Feet ☐ AND b. Inches ☐☐ OR c. Centimetres ☐☐☐

C7) Please tell us your current weight:
Please either enter the number of whole stones in one box (e.g. 10) and the pounds in the next box (e.g.7), or, alternatively, enter the number of kilograms in the third box to one decimal place (e.g. 70.5).

a. Stones ☐☐ AND b. Pounds ☐☐ OR c. Kilograms ☐☐☐

C8) Have you ever had a menstrual period?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question C9 on page 20**

a. When did you last have a menstrual period?

In the past 3 months 1 ○ → **Please go to b on the next page**

4-12 months ago 2 ○

More than 12 months ago 3 ○ Can't remember 9 ○

i) Why have your periods stopped? *Please select all that apply.*

You had a hysterectomy 1 ☐

You were/are pregnant 2 ☐

You were/are breastfeeding 3 ☐

You have a hormonal coil 4 ☐

You are going through or have been through the menopause 5 ☐

Other reason 6 ☐
Please cross and describe

Don't know 9 ☐

19178

b. Which of the following statements best describes your current menopause status?

I have been through the menopause	1 ○ →	**Please continue to (i) below**
I am going through the menopause now	2 ○ →	**If any of these answers, please go to question c* on the next page**
I have not yet started going through the menopause	3 ○ →	
I am not sure	4 ○ →	
I prefer not to answer	5 ○ →	

(i) For each of the following items, if you remember experiencing them when you were going through the menopause, please indicate how **bothered** you were by each one on a scale of 1 to 6, where 1 is 'not at all bothered' and 6 is 'extremely bothered'. If you did not experience an item, please select 'no'.

			Yes, not at all bothered					Yes, extremely bothered
		No	1	2	3	4	5	6
A.	Hot flushes	0 ○	○	○	○	○	○	○
B.	Night sweats	0 ○	○	○	○	○	○	○
C.	Difficulty sleeping	0 ○	○	○	○	○	○	○
D.	Change in your sexual desire	0 ○	○	○	○	○	○	○
E.	Vaginal dryness	0 ○	○	○	○	○	○	○

(ii) For each of the following items, please indicate whether you have experienced them in the past month and how bothered you are by each one on a scale of 1 to 6, where 1 is 'not at all bothered' and 6 is 'extremely bothered'. If you did not experience an item, please select no.

		No	Yes, not at all bothered 1	2	3	4	5	Yes, extremely bothered 6
A.	Hot flushes	0 ○	○	○	○	○	○	○
B.	Night sweats	0 ○	○	○	○	○	○	○
C.	Difficulty sleeping	0 ○	○	○	○	○	○	○
D.	Change in your sexual desire	0 ○	○	○	○	○	○	○
E.	Vaginal dryness	0 ○	○	○	○	○	○	○

c*. Do you use hormone replacement therapy (HRT) nowadays?

Yes 1 ○ No 0 ○ ➡ **If <u>no</u>, please go to question C9 below**

i) Do you use any of the following?

A.	HRT tablets	Yes 1 ○	No 0 ○
B.	HRT patches	Yes 1 ○	No 0 ○
C.	HRT cream?	Yes 1 ○	No 0 ○

C9) Nowadays how frequently do you:

		Often	Sometimes	Not at all
a.	Need to rush to the toilet	2 ○	1 ○	0 ○
b.	Have difficulty in starting to pee (hesitancy)	2 ○	1 ○	0 ○
c.	Strain or take a long time peeing	2 ○	1 ○	0 ○
d.	Have a weak flow of urine	2 ○	1 ○	0 ○
e.	Feel that your bladder has not fully emptied	2 ○	1 ○	0 ○
f.	Wake up frequently during the night to pee (at least 2 times per night)	2 ○	1 ○	0 ○

Please cross through circles like this in BLACK PEN: ⊗

C10) Have you ever been told by a doctor, or other health professional, that you have:

		Yes	No	Don't know	Not applicable
a.	Gynaecomastia (breast swelling and tenderness)	1 ○	0 ○	9 ○	8 ○
b.	Erectile dysfunction	1 ○	0 ○	9 ○	8 ○
c.	Prostatitis	1 ○	0 ○	9 ○	8 ○
d.	An enlarged prostate	1 ○	0 ○	9 ○	8 ○
e.	Other problem with penis or prostate *Please cross and describe*	1 ○	0 ○	9 ○	8 ○

If you are affected by any of the issues raised in this section, you may wish to seek support from:

YOUR LOCAL GP
Children of the 90s always recommend that you speak to your GP (doctor) if you have any concerns about your physical or mental health.

www.nhs.uk/nhs-services/services-near-you/

PAIN SUPPORT
Help and support for people in pain.

painuk.org/help-and-support

ANXIETY UK
User-led organisation, supporting people with anxiety disorders, including PTSD.

www.anxietyuk.org.uk

Tel: 03444 775 774
(9:30am-5:30pm Mon-Fri)

Section D: Eating

We would like to collect information about your eating, weight and exercise. Remember there are no right or wrong answers, we just want to know what you think. If you would prefer not to answer, please move to the next section.

D1) In the **last year**:

		Not at all 0	1	Slightly 2	3	Moderately 4	5	Extremely 6
a.	Have you felt fat?	○	○	○	○	○	○	○
b.	Have you had a definite fear that you might gain weight or become fat?	○	○	○	○	○	○	○
c.	Has your weight influenced how you think about (judge) yourself as a person?	○	○	○	○	○	○	○
d.	Has your shape influenced how you think about (judge) yourself as a person?	○	○	○	○	○	○	○

D2) Have there been times when you felt you have eaten what other people would regard as an unusually large amount of food (e.g., a whole tub of ice cream (450mls or more)) given the circumstances?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question D3 on the next page**

a. During the times when you ate an unusually large amount of food, did you experience a loss of control (feel you couldn't stop eating or control what or how much you were eating)?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question D3 on the next page**

b. **At its worst**, how many **TIMES per week** on average did you eat an unusually large amount of food and experience a loss of control?

1	2	3	4	5	6	7
○	○	○	○	○	○	○

c. Do you feel very upset about these episodes of uncontrollable overeating or the resulting weight gain?

Yes 1 ○ No 0 ○

D3) Have you made yourself vomit to prevent weight gain or counteract the effects of eating?

Yes 1 ○ No 0 ○ → **If no, please go to question D4 below**

a. **At its worst**, how many **TIMES per week** on average did you make yourself vomit to prevent weight gain or counteract the effects of eating?

1	2	3	4	5	6	7
○	○	○	○	○	○	○

D4) Have you used laxatives, diuretics or other medicines to prevent weight gain or counteract the effects of eating?

Yes 1 ○ No 0 ○ → **If no, please go to question D5 below**

a. **At its worst**, how many **TIMES per week** on average have you used laxatives or diuretics to prevent weight gain or counteract the effects of eating?

1	2	3	4	5	6	7
○	○	○	○	○	○	○

D5) Have you fasted (skipped at least 2 meals in a row) to prevent weight gain or counteract the effects of eating?

Yes 1 ○ No 0 ○ → **If no, please go to question D6 below**

a. **At its worst**, how many **TIMES per week** on average did you fast (skip at least 2 meals in a row) to prevent weight gain or counteract the effects of eating?

1	2	3	4	5	6	7
○	○	○	○	○	○	○

D6) Have you engaged in exercise **specifically** to prevent weight gain or counteract the effects of eating?

Yes 1 ○ No 0 ○ → **If no, please go to question D7 on the next page**

a. **At its worst**, how many **TIMES per week** on average have you engaged in exercise **specifically** to prevent weight gain or counteract the effects of eating?

1	2	3	4	5	6	7
○	○	○	○	○	○	○

continued on the next page...

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b. Did you engage in exercise even if sick or injured?

Yes 1 ○ No 0 ○

c. Was it difficult for you to do your work or daily tasks because of the amount of time that you were exercising to lose weight or prevent weight gain?

Yes 1 ○ No 0 ○

D7) **In the last year** did you make yourself vomit, use laxatives or diuretics or other medication, fast, engage in excessive exercise only in the context of eating large amounts of food with loss of control?

Yes 1 ○ No 0 ○

If you are affected by any of the issues raised in this section, you may wish to seek support from:

BEAT

The UK's eating disorder charity

www.b-eat.co.uk
Tel: 0345 634 1414

Alternatively, there are a number of organisations listed at the back of the questionnaire.

Section E: Your Feelings

Please cross through circles like this in BLACK PEN: ⊗

The questions in this section ask you about your feelings and the way you behave.

We realise that you may find some of these questions upsetting. If you prefer not to answer these questions, please leave them blank.

You can find information for support organisations on our helplines page.

You may have answered these questions in previous questionnaires, but you might be feeling differently now and it's important that we understand changes over time.

E1) Please indicate the way you have felt in the **past week**:

a. I have been able to laugh and see the funny side of things

As much as I always could	3 ○	Not quite so much now	2 ○
Definitely not so much now	1 ○	Not at all	0 ○

b. I have looked forward with enjoyment to things

As much as I ever did	3 ○	Rather less than I used to	2 ○
Definitely less than I used to	1 ○	Hardly at all	0 ○

c. I have blamed myself unnecessarily when things went wrong

Yes, most of the time	3 ○	Yes, some of the time	2 ○
Not very often	1 ○	No, never	0 ○

d. I have been anxious or worried for no good reason

No, not at all	0 ○	Hardly ever	1 ○
Yes, sometimes	2 ○	Yes, often	3 ○

e. I have felt scared or panicky for no very good reason

Yes, quite a lot	3 ○	Yes, sometimes	2 ○
No, not much	1 ○	No, not at all	0 ○

continued on the next page...

continued:

f. Things have been getting on top of me

Yes, most of the time	3 ○	Yes, sometimes	2 ○
No, hardly ever	1 ○	No, not at all	0 ○

g. I have been so unhappy that I have had difficulty sleeping

Yes, most of the time	3 ○	Yes, sometimes	2 ○
Not very often	1 ○	No, not at all	0 ○

h. I have felt sad or miserable

Yes, most of the time	3 ○	Yes, sometimes	2 ○
Not very often	1 ○	No, not at all	0 ○

i. I have been so unhappy that I have been crying

Yes, most of the time	3 ○	Yes, quite often	2 ○
Only occasionally	1 ○	No, never	0 ○

j. The thought of harming myself has occurred to me

Yes, quite often	3 ○	Sometimes	2 ○
Hardly ever	1 ○	Never	0 ○

E2) Please indicate the way you feel nowadays:

		Very often	Often	Not very often	Never
a.	Do you feel upset for no obvious reason?	3 ○	2 ○	1 ○	0 ○
b.	Have you felt as though you might faint?	3 ○	2 ○	1 ○	0 ○
c.	Do you feel uneasy and restless?	3 ○	2 ○	1 ○	0 ○
d.	Do you sometimes feel panicky?	3 ○	2 ○	1 ○	0 ○
e.	Do you worry a lot?	3 ○	2 ○	1 ○	0 ○
f.	Do you feel strung-up inside?	3 ○	2 ○	1 ○	0 ○
g.	Do you ever have the feeling you are going to pieces?	3 ○	2 ○	1 ○	0 ○
h.	Do you have bad dreams which upset you when you wake up?	3 ○	2 ○	1 ○	0 ○

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

E3) Over the **past two weeks** how often have you been bothered by the following problems?

		Not at all	Less than half the days	More than half the days	Nearly every day
a.	Feeling nervous, anxious or on edge	0 ○	1 ○	2 ○	3 ○
b.	Not being able to stop or control worrying	0 ○	1 ○	2 ○	3 ○
c.	Worrying too much about different things	0 ○	1 ○	2 ○	3 ○
d.	Trouble relaxing	0 ○	1 ○	2 ○	3 ○
e.	Being so restless that it is hard to sit still	0 ○	1 ○	2 ○	3 ○
f.	Becoming easily annoyed or irritable	0 ○	1 ○	2 ○	3 ○
g.	Feeling afraid as though something awful might happen	0 ○	1 ○	2 ○	3 ○

E4) For the next four statements please tell us how much you feel they are like you:

		Not at all like me	A little bit like me	Moder-ately like me	Quite a bit like me	Extre-mely like me
a.	I often have the feeling that I would just like to run away	0 ○	1 ○	2 ○	3 ○	4 ○
b.	I feel powerless to change things	0 ○	1 ○	2 ○	3 ○	4 ○
c.	I feel trapped inside myself	0 ○	1 ○	2 ○	3 ○	4 ○
d.	I feel I'm in a deep hole I can't get out of	0 ○	1 ○	2 ○	3 ○	4 ○

The following questions are about thoughts of suicide and hurting yourself on purpose, also sometimes referred to as self-harm. We know this is a sensitive subject, but it is important to ask about it now, as it is not uncommon. By finding out about self-harm we can find ways of helping people.

We realise that you may find some of these questions upsetting. If you prefer not to answer these questions, please leave them blank.

You can find information for support organisations on our helplines page.

If you do not want to answer questions on this topic please go to section F on page 32.

E5) Has anyone in your family died by suicide / taken their own life?

Yes 1 ○ No 0 ○ → **If no, please go to question E6 below**

a. Who in your family has done this? *Please select all that apply.*

Parent 1 ☐ Brother or sister 2 ☐ Children of the 90s study child 3 ☐

Other child 4 ☐ Your partner 5 ☐ Someone else 6 ☐ *Please cross and describe*

b. How old were you when you experienced your **first** loss of a family member to suicide? ☐☐ years old

E6) Have any of your close friends died by suicide / taken their own life?

Yes 1 ○ No 0 ○ → **If no, please go to question E7 on the next page**

a. How old were you when you experienced your **first** loss of a friend to suicide? ☐☐ years old

E7) Has anyone in your family (not including yourself) ever hurt themselves on purpose (e.g. by taking an overdose of pills, or by cutting themselves)?
Please do not include a family member who has died by suicide.

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question E8 below**

a. Who in your family has done this? *Please select all that apply.*

Parent 1 ☐ Brother or sister 2 ☐ Children of the 90s study child 3 ☐

Other child 4 ☐ Your partner 5 ☐ Someone else 6 ☐ *Please cross and describe*

b. How old were you when this first happened? ☐☐ years old

E8) Have any of your close friends **ever** hurt themselves on purpose (e.g. by taking an overdose of pills, or by cutting themselves)?
Please do not include a friend who has died by suicide.

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question E9 below**

a. How old were you when this **first** happened? ☐☐ years old

E9) Have you **ever** hurt yourself on purpose in any way (e.g. by taking an overdose of pills, or by cutting yourself)?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to question E10 on page 31**

a. How many times have you done this **in the last year**?

Not in the past year 0 ○ Once 1 ○

2-5 times 2 ○ 6-10 times 3 ○

More than 10 times 4 ○

continued on the next page...

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b. Have you ever hurt yourself on purpose (e.g. by taking an overdose of pills, or by cutting yourself), without intending to kill yourself?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to c below**

(i) When was the last time you hurt yourself on purpose, without intending to kill yourself?

In the last week 1 ○ More than a week ago but in the last year 2 ○

More than a year ago 3 ○

c. On any of the occasions you have hurt yourself on purpose, have you ever seriously wanted to kill yourself?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to d below**

(i) When was the last time you hurt yourself on purpose and you seriously wanted to kill yourself?

In the last week 1 ○ More than a week ago but in the last year 2 ○

More than a year ago 3 ○

d. **In your lifetime**, do any of the following reasons help to explain why you have hurt yourself on purpose? *Please select all that apply.*

I wanted to show how desperate I was feeling	1 ☐
I wanted to die	2 ☐
I wanted to punish myself	3 ☐
I wanted to frighten someone	4 ☐
I wanted to get relief from a terrible state of mind	5 ☐
Some other reason *Please cross and describe*	6 ☐

e. How old were you when this **first** happened? ☐☐ years old

19178

E10) Have you **ever** thought of killing yourself, even if you would not really do it?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to section F on the next page.**

a. When was the **last time** you felt like this?

In the last week 1 ○ More than a week ago but in the last year 2 ○

More than a year ago 3 ○

b. Have you **ever** made plans to kill yourself?

Yes 1 ○ No 0 ○ → **If <u>no</u>, please go to d below**

c. When was the **last time** you felt like this?

In the last week 1 ○ More than a week ago but in the last year 2 ○

More than a year ago 3 ○

d. Did your religious beliefs, or lack of them, play a role in:

	Yes, my belief did	Yes, my lack of belief did	No	Don't know	Prefer not to answer
(i) Making a plan to do it?	1 ○	2 ○	0 ○	9 ○	8 ○
(ii) Preventing you from following through with it?	1 ○	2 ○	0 ○	9 ○	8 ○

If you are affected by any of the issues raised in this section, you may wish to seek support from:

SAMARITANS
Emotional support for everyone
samaritans.org
Tel: 116 123 (24 hours)

19178

Section F: More About Your Feelings

This section asks about how you feel about certain things and any unusual experiences you might have had.

F1) Please respond to the following questions on a scale from 0 to 10:

a. My relationships are as satisfying as I would want them to be.

	0	1	2	3	4	5	6	7	8	9	10	
Strongly disagree	○	○	○	○	○	○	○	○	○	○	○	Strongly agree

b. How often do you worry about being able to meet normal monthly living expenses?

	0	1	2	3	4	5	6	7	8	9	10	
Worry all of the time	○	○	○	○	○	○	○	○	○	○	○	Do not ever worry

c. How often do you worry about safety, food, or housing?

	0	1	2	3	4	5	6	7	8	9	10	
Worry all of the time	○	○	○	○	○	○	○	○	○	○	○	Do not ever worry

These questions are about things you experience:

F2) Have you **ever** heard voices that other people couldn't hear?

Yes, definitely 2 ○ Yes, maybe 1 ○ No, never 0 ○ → **If <u>no</u>, please go to question F3 below**

a. How often have you heard voices that other people couldn't hear in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

F3) Have you **ever** seen something or someone that other people couldn't see?

Yes, definitely 2 ○ Yes, maybe 1 ○ No, never 0 ○ → **If <u>no</u>, please go to F4 on the next page**

a. How often have you seen things that other people couldn't see in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

F4) Have you **ever** thought you were being followed or spied on?

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If <u>no</u>, please go to question F5 below**

a. How often have you thought you were being followed or spied on in the **past year**?

Once or twice 1 ○ | Less than once a month 2 ○ | More than once a month 3 ○ | Nearly every day 4 ○ | Not at all 0 ○

F5) Have you **ever** believed that people were following you or spying on you as part of a plot to harm you in some way, and which your family or friends did not believe existed?

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If <u>no</u>, please go to question F6 below**

a. How often have you believed that people were following you or spying on you as part of a plot, in the **past year**?

Once or twice 1 ○ | Less than once a month 2 ○ | More than once a month 3 ○ | Nearly every day 4 ○ | Not at all 0 ○

F6) Some people believe that other people can read their thoughts. Have other people **ever** read your thoughts?

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If <u>no</u>, please go to question F7 below**

a. How often have you believed that other people can read your thoughts in the **past year**?

Once or twice 1 ○ | Less than once a month 2 ○ | More than once a month 3 ○ | Nearly every day 4 ○ | Not at all 0 ○

b. Do you think people have sometimes used special powers to read your thoughts?

Yes definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○

F7) Have you **ever** believed that you were being sent special messages through the television or the radio, or that a programme had been arranged just for you alone?

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If <u>no</u>, please go to F8 on the next page**

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a. How often have you been sent special messages in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

F8) Have you **ever** felt that you were under the control of some special power?

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If <u>no</u>, please go to question F9 below**

a. How often have you thought you were under the control of a special power in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

b. Who did you think was controlling you (at any time in the past)?

God or other religious figure 1 ○ | A computer or machine 2 ○

Someone or something else 3 ○ | Don't know 9 ○

c. Did it control what you were doing or thinking, such that you had no will of your own?

Yes definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○

F9) Have you **ever** felt that you are somebody really very special, or that you have special powers like reading people's minds, or that you have been chosen to perform great and special tasks?
This doesn't mean that you are just clever or that you come from an important family.

Yes, definitely 2 ○ | Yes, maybe 1 ○ | No, never 0 ○ → **If <u>no</u>, please go to question F10 on the next page**

a. How often have you thought you are somebody really very special, or that you have special powers in the **past year**?

Once or twice	Less than once a month	More than once a month	Nearly every day	Not at all
1 ○	2 ○	3 ○	4 ○	0 ○

Please cross through circles like this in BLACK PEN: ⊗
*If you make a mistake, fill in the **wrong** circle like this:* ●

F10) Please consider each of the following statements. How often have you been feeling like this in the **past two weeks**?

		None of the time	Rarely	Some-times	Often	All the time
a.	I've been feeling optimistic about the future	0 ○	1 ○	2 ○	3 ○	4 ○
b.	I've been feeling useful	0 ○	1 ○	2 ○	3 ○	4 ○
c.	I've been feeling relaxed	0 ○	1 ○	2 ○	3 ○	4 ○
d.	I've been feeling interested in other people	0 ○	1 ○	2 ○	3 ○	4 ○
e.	I've had energy to spare	0 ○	1 ○	2 ○	3 ○	4 ○
f.	I've been dealing with problems well	0 ○	1 ○	2 ○	3 ○	4 ○
g.	I've been thinking clearly	0 ○	1 ○	2 ○	3 ○	4 ○
h.	I've been feeling good about myself	0 ○	1 ○	2 ○	3 ○	4 ○
i.	I've been feeling close to other people	0 ○	1 ○	2 ○	3 ○	4 ○
j.	I've been feeling confident	0 ○	1 ○	2 ○	3 ○	4 ○
k.	I've been able to make up my own mind about things	0 ○	1 ○	2 ○	3 ○	4 ○
l.	I've been feeling loved	0 ○	1 ○	2 ○	3 ○	4 ○
m.	I've been interested in new things	0 ○	1 ○	2 ○	3 ○	4 ○
n.	I've been feeling cheerful	0 ○	1 ○	2 ○	3 ○	4 ○

F11) Please respond to the following questions on a scale from 0 to 10:

a. Overall, how satisfied are you with life as a whole these days?

	0	1	2	3	4	5	6	7	8	9	10	
Not satisfied at all	○	○	○	○	○	○	○	○	○	○	○	Completely satisfied

b. In general, how happy or unhappy do you usually feel?

	0	1	2	3	4	5	6	7	8	9	10	
Extremely unhappy	○	○	○	○	○	○	○	○	○	○	○	Extremely happy

c. In general, how would you rate your physical health?

	0	1	2	3	4	5	6	7	8	9	10	
Poor	○	○	○	○	○	○	○	○	○	○	○	Excellent

d. How would you rate your overall mental health?

	0	1	2	3	4	5	6	7	8	9	10	
Poor	○	○	○	○	○	○	○	○	○	○	○	Excellent

e. Overall, to what extent do you feel the things you do in your life are worthwhile?

	0	1	2	3	4	5	6	7	8	9	10	
Not at all worthwhile	○	○	○	○	○	○	○	○	○	○	○	Completely worthwhile

f. I understand my purpose in life.

	0	1	2	3	4	5	6	7	8	9	10	
Strongly disagree	○	○	○	○	○	○	○	○	○	○	○	Strongly agree

g. I always act to promote good in all circumstances, even in difficult and challenging situations.

	0	1	2	3	4	5	6	7	8	9	10	
Not true of me	○	○	○	○	○	○	○	○	○	○	○	Completely true of me

h. I am always able to give up some happiness now for greater happiness later.

	0	1	2	3	4	5	6	7	8	9	10	
Not true of me	○	○	○	○	○	○	○	○	○	○	○	Completely true of me

i. I am content with my friendships and relationships.

	0	1	2	3	4	5	6	7	8	9	10	
Strongly disagree	○	○	○	○	○	○	○	○	○	○	○	Strongly agree

If you are affected by any of the issues raised in this section, you may wish to seek support from:

MIND - Advice and support for anyone with a mental health problem
mind.org.uk **Tel: 0300 123 3393** **Text: 86463**

19178

Section G: Your Finances

With the current cost of living crisis in the UK, we want to know about the difficulties you might be experiencing paying the bills. If you live in another country, we would still like to know about the difficulties you might be having.

G1) How well would you say your household are managing financially **at the moment**?

Living comfortably	1 ○	Doing alright	2 ○
Just about getting by	3 ○	Finding it quite difficult	4 ○
Finding it very difficult	5 ○	Prefer not to say	9 ○

G2) In the **last year**, have you experienced any difficulties paying for:
If you don't pay for these, please select 'not applicable'.

	No	Yes, some-times	Yes, all the time	Not appli-cable
a. Clothes	0 ○	1 ○	2 ○	9 ○
b. Rent/mortgage	0 ○	1 ○	2 ○	9 ○
c. Travel, e.g. fuel or bus fares	0 ○	1 ○	2 ○	9 ○
d. Childcare	0 ○	1 ○	2 ○	9 ○
e. Utility bills, e.g. gas, electric, water, broadband	0 ○	1 ○	2 ○	9 ○
f. Other bills such as mobile phone, council tax	0 ○	1 ○	2 ○	9 ○
g. Other regular outgoings such as loan repayments	0 ○	1 ○	2 ○	9 ○

G3) Are you worried that **in the coming weeks** you will experience difficulties paying for:

	No	Yes, a little	Yes, very	Not appli-cable
a. Food	0 ○	1 ○	2 ○	9 ○
b. Clothes	0 ○	1 ○	2 ○	9 ○
c. Rent/mortgage	0 ○	1 ○	2 ○	9 ○
d. Travel e.g. fuel or bus fares	0 ○	1 ○	2 ○	9 ○
e. Childcare	0 ○	1 ○	2 ○	9 ○
f. Utility bills, e.g. gas, electric, water, broadband	0 ○	1 ○	2 ○	9 ○
g. Other bills such as mobile phone, council tax	0 ○	1 ○	2 ○	9 ○
h. Other regular outgoings such as loan repayments	0 ○	1 ○	2 ○	9 ○

G4) How much do you agree/disagree with the following statements **today**?

	Strongly agree	Agree	Neither agree nor disagree	Dis-agree	Strongly dis-agree	Not appli-cable
a. I worry about paying the rent/mortgage	1 ○	2 ○	3 ○	4 ○	5 ○	9 ○
b. I worry about getting evicted/having my home repossessed	1 ○	2 ○	3 ○	4 ○	5 ○	9 ○
c. I worry about keeping warm in the winter	1 ○	2 ○	3 ○	4 ○	5 ○	9 ○
d. I worry about having enough to eat	1 ○	2 ○	3 ○	4 ○	5 ○	9 ○
e. I worry I might lose my job	1 ○	2 ○	3 ○	4 ○	5 ○	9 ○

G5) Do you ever cut the size of your meals, or skip meals, because there isn't enough money for food?

Yes 1 ○

No 0 ○ → **If no, don't know, or prefer not to say, please go to question C6 below**

Don't know 9 ○ →

Prefer not to say 8 ○ →

a. **If yes**, how often do you or others cut the size of meals or skip meals?

Almost every day 1 ○ Some days but not every day 2 ○

1 or 2 days a week 3 ○ Don't know 9 ○

Prefer not to say 8 ○

G6) Do you or anyone in your household ever eat less than you feel you should because there isn't enough money for food?

Yes 1 ○ No 0 ○ Don't know 9 ○

Prefer not to say 8 ○

G7) Are you ever hungry but don't eat because there isn't enough money for food?

Yes 1 ○ No 0 ○ Don't know 9 ○

Prefer not to say 8 ○

G8) Have you or your family received any food from any of the following people/organisations?
Please select all that apply, or no.

		No	Before pandemic (Jan-Feb 2020)	During pandemic (Mar 2020 -Mar 2021)	In the last 3 months
a.	Food banks	0 ☐	1 ☐	2 ☐	3 ☐
b.	Free food provided by schools	0 ☐	1 ☐	2 ☐	3 ☐
c.	Food provided by community organisations/allotment schemes	0 ☐	1 ☐	2 ☐	3 ☐
d.	Meals on wheels	0 ☐	1 ☐	2 ☐	3 ☐
e.	Food from faith based organisations	0 ☐	1 ☐	2 ☐	3 ☐
f.	Food from friends/neighbours	0 ☐	1 ☐	2 ☐	3 ☐
g.	Food from family (not living in home)	0 ☐	1 ☐	2 ☐	3 ☐
h.	Other *Please cross and describe below*	0 ☐	1 ☐	2 ☐	3 ☐

If you are affected by any of the issues raised in this section, you may wish to seek support from:

Your local Citizens Advice Bureau (CAB)

Offers independent advice on a range of issues including housing, debt and consumer issues.

citizensadvice.org.uk

Tel: **0800 144 8848**

Section H: Gender

H1) Which of the following most accurately describe(s) you?
Please choose as many as you like.

Female	1 ☐	
Male	2 ☐	
Non-binary	3 ☐	
Transgender	4 ☐	
Intersex	5 ☐	
Let me tell you *Please cross and describe*	6 ☐	
I prefer not to say	7 ☐	

H2) Many people feel that they are a mixture of masculine and feminine characteristics regardless of their gender. Please rate how much you see yourself as such a mixture on a scale of 1 to 10:

100% masculine					Equal					100% feminine
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
○	○	○	○	○	○	○	○	○	○	○

I don't think in these terms	77 ○	
Don't know	99 ○	
Prefer not to answer	88 ○	

Completing the Questionnaire

I1) What is your **date of birth**? DD / MM / YYYY 1 9

I2) What is **today's date**? DD / MM / YYYY 2 0

Attend your @30 clinic visit and receive a £40 voucher!
Parents are now invited to attend our @30 clinic. Please update your details at:
childrenofthe90s.ac.uk/update-your-details
so that we can send you an invite. We offer a range of days & times, and you can attend with your family/partner too.

We are also always trying to find ways to reduce our paper use. To ensure that we send you your questionnaires via your preferred method, can you please let us know how you would like to complete your questionnaires? If you choose 'online' we will no longer send out paper questionnaires as part of our reminder process.

Online 1 ○ Paper 2 ○

Extra space for answering questions
Please clearly indicate the question number(s) your answer applies to.

Thank you!

Many thanks for completing your questionnaire. The information you provide is really important to our ongoing research.

19178

Parent Winter 2023 Questionnaire

STRICTLY CONFIDENTIAL (when completed)

Version 1 08/02/2023

Questionnaire Number

If you'd like to add a comment, please do so in the box below.
Please cross this box if you would like us to reply: ☐

When completed, please send this back in the freepost envelope provided, or post to this address. If you do not wish to complete this questionnaire, please leave it blank and return it to us. We will then know not to send you any more reminders.

Freepost (RRXX-UUZG-HTLK)
Children of the 90s
Oakfield House
15-23 Oakfield Grove
Bristol
BS8 2BN

If you **would like to receive** a thank you voucher for completing your questionnaire, please **cross this box**: ☐
Children of the 90s will send your voucher to the email/postal address we have listed on our records. Vouchers will be sent within 4 weeks of receiving your questionnaire using the details we hold for you.
If you want to update the details that we have for you please visit:
childrenofthe90s.ac.uk/update-your-details

To be entered into the prize draw we must have received your questionnaire by midnight on Monday 17th April 2023. If you win, we will contact you within two weeks using the contact details on our database. You will receive your prize up to six weeks after the draw has been held.

If you **don't** wish to be entered into the prize draw, please cross this box.

No Prize Draw ☐

19178